JUNE 2018

CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST
REDESIGNING CARE DELIVERY: BUILDING THE TEAM AROUND THE PATIENT

The organisation

Chesterfield Royal Hospital NHS Foundation Trust (Chesterfield Royal) employs 3,900 staff and serves a population of over 400,000 people from the communities of North Derbyshire and the surrounding area.

Background

In recent years the trust has experienced a shortage in the number of registered nurses across its workforce. Despite a concerted effort, including proactive recruitment campaigns, Chesterfield Royal had exhausted all available options to recruit to nursing posts.

In addition to the recruitment challenges, the organisation also recognised that development opportunities for band 3 roles were limited and so the trust wanted to explore opportunities to improve this.

This case study reflects on how Chesterfield Royal has successfully piloted an approach to redesigning its team structure, how it addressed the issues the process presented, and the organisation's current position: where other wards are looking to adopt the new team structure.

What the trust did

As the organisation was unable to make up for the shortfall in nursing, Chesterfield Royal decided to explore the possibility of introducing a new workforce model to ensure the best use of the staff and the skills already available in teams. In redesigning the care delivery teams, the trust looked at how it could make use of newly introduced band 4 roles, such as the nursing associate and the assistant practitioner, to build a team around patient needs, based on identifying the skills needed to deliver the best care.

First steps

The proposal started with a conversation in the senior leadership team which was shared with the board to gain support. The heads of nursing and therapies

had this on their respective agendas and discussions were held with professional standards groups.

Recognising that a new staffing model would require a cultural, as well as a structural change for the wards involved, the leadership team was keen to ensure that staff were involved in the process from the outset. There was a clear message that this would not be forced onto any ward or team and only introduced where there was an appetite to do so.

Project leaders knew that staff engagement would be key to embedding the role of assistant practitioner, and later the nursing associate, in order to extend the scope of roles below band 5. Group sessions were held specifically for the ward matrons who were asked for thoughts about the work the band 2 and band 3 staff were currently doing, and explored the art of the possible to understand whether and how these staff could be used differently to help support the work of the wider team.

Information about the pilot was cascaded by the matrons to their teams, and those wanting to hear more were encouraged to attend open forum sessions that were arranged discuss the proposals. Eight sessions were held over two months, with two additional sessions held for the therapy services.

Staff were encouraged to talk openly about any worries or concerns they had, and to ask questions so that the sessions could be used to address these areas of concern. The use of email was deliberately kept to a minimum with the project leaders preferring to meet with staff and discuss any issues directly.

How they did it

Once participating pilot wards had been identified, multi-professional team days were arranged. These were structured, and started by setting the context and introducing the vision of building a team around the patient. From the outset it was made clear that the main driver for this change was not about finance, or introducing top-down change, but wanting to do something that would provide best care for patients while also making things better for the staff.

Staff were rostered to attend the workshops and each day had a mix of staff, including registered nurses, healthcare assistants and therapists.

The matrons ran these sessions to talk about how the model would work in practice and answer any questions. The overall approach was not to try and create a full model from beginning to end, but to break it down into small chunks with lots of discussion. For example, an idea would be presented, staff would then think about why it might be good, identify concerns, and then make any adjustments needed.

A task analysis exercise was used splitting the staff into small groups with each group being asked to list the different aspects of care that patients on their ward need. They were then asked to map these against the skills and knowledge required to deliver that care. This exercise enabled the staff to identify that while a lot of the team had the skills to deliver many aspects of care, certain elements can only be done by a registered nurse or therapist.

Applying this to the model of care delivery, the team identified that having someone who could undertake tasks such as moving and handling, administering medication, or assessing a patient for a walking aid, would free up senior members of the team to do the things that only they could do.

Overcoming challenges

When assistant practitioners were first appointed there was some resistance from nursing staff and healthcare assistants. On reflection, it is possible that these staff felt their own roles were under threat. The first six months of the pilot were the most difficult, but staff came to realise the potential for these new roles which are now fully accepted within the teams.

A focus group was established for the trainees during the pilot to help unpick issues they experienced and offer peer support. They also used this to raise any issues with the matrons, who in turn hosted information sessions for the other staff.

Being mindful of the impact on the ward, management tried to ensure it only had one learner on rota in each of the areas, however, as the programme rolled out this wasn't always possible. With some individuals needing extra educational support, each ward was reviewed separately with a view to vacancies, learners, and gaps on the rota.

Outcome

Since introduction, the nursing associate and assistant practitioner roles have been transitioned onto rotas as part of a team providing care on a 12-hour shift system, across a seven-day period.

The new roles have enabled band 5 staff to work to the top of their licenses. This is not only important for the model to work, but to also provide a career pathway for healthcare assistants looking to further their development.

The numbers involved have helped to establish a peer support model and maintain momentum. The trust introduced 19 assistant practitioners in 2016, followed by 10 nursing associates the following year. In February 2018, a further 19 nursing associates were appointed from 120 applications.

Conclusion and lessons learned

The approach taken by Chesterfield Royal to redesign the care delivery teams and engage existing staff through the pilot has enabled the trust to successfully introduce the assistant practitioner and nursing associate roles.

Staff were involved through workshop sessions co-facilitated with the head of practice and professional development and the head of nursing. Having this mix of expertise on how the model could work in practice, and the authority to make decisions to help make this work, helped to maintain momentum.

Involving staff in the process from the outset has instilled a sense of ownership among the teams involved. Registered nurses are now practicing at the top of their license and using the full extent of their education and training, instead of spending time doing things that can be done by less qualified professionals.

Top tips

- Gain strategic support from board members and senior leaders.
- Involve staff from the beginning to instill a sense of ownership.
- Support ward matrons to run sessions with their teams.
- Discuss how the model will work in practice and answer any questions.
- Listen to concerns – be willing to reflect and change.
- Be clear the driver is about improving things for patients and staff - not financial savings.

Find out more

For more information about how this model was implemented please contact Maxine Simmons, head of practice and professional development, via

maxine.simmons@nhs.net

Contact us

NHS Employers
2 Brewery Wharf
Kendell Street
Leeds LS10 1JR

www.nhsemployers.org
enquiries@nhsemployers.org

@nhsemployers
NHS Employers
www.youtube.com/nhsemployers